BEHLER
EYE & LASER CENTER

HIPAA – NOTICE OF PRIVACY PRACTICES

Patient _____ DOB: ____ / ____ / ____ Date: ____ / ____ / ____

I hereby acknowledge that I received Behler Eye and Laser Center's Notice of Privacy Pracices.

_____ _____

Patient Signature Date

I may be contacted by phone in the following manner (check all that apply):

Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

- ☐ Please leave a detailed message
- ☐ Please leave a call back number only
- ☐ Please leave a message with my:
  - ☐ Spouse: _____
  - ☐ Caregiver: _____
  - ☐ Adult Children: _____
  - ☐ Other: _____

Persons who may receive information about my care are: _____

_____

_____

Additional HIPAA compliance notification information is available at your request